INDIANA
HIV
JURISDICTIONAL
PLAN
2015 - 2016

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Executive Summary

The 2015-2016 Indiana Statewide HIV Prevention Plan is designed to establish the roadmap for HIV services that will have the greatest impact on communities at highest risk for acquiring and/or transmitting HIV. The HIV Prevention Plan contains information related to the HIV prevention needs in Indiana. The plan includes: the description of the Indiana State Department of Health (ISDH) HIV Prevention Programs, Epidemiologic Profile Executive Summary, Prevention and Care Resources for the State of Indiana, and the description and history of the Indiana HIV Prevention Community Planning Group (CPG).

Epidemiological Profile Executive Summary

Demographics:

The demographic information for Indiana used throughout this report is based on the 2010 Census Bureau population estimate. Indiana is a mostly rural state with several urban and metropolitan centers that had an estimated population of 6,483,802 people. The majority of the population (84.0%) is White and Non Hispanic, followed by Blacks (9.1%). The rest is comprised of people of Asian/ Pacific Islander and American Indian/Alaskan Native origin. The population is predominantly Non Hispanic (94.0%), with a small, but fast growing Hispanic minority. According to the 2010 Census Estimates, 6.0% of the population selected Hispanic as their Ethnicity.

Prevalence:

By the end of December 2013, a total of 11,222 persons were living with HIV/AIDS (PLWHA) in the state of Indiana, up from 10,746 persons by the end of 2012. The disease continues to be male dominated, with the number of diagnosed males four times higher than that of females. The rate of infection was at 282.4 for males and 67.2 for females per 100,000 people of the general population. The majority of PLWHA are in their middle ages, ranging from 40 to 49 years of age. However, the majority of people are first diagnosed at the ages of 20 to 24 years of age.

Around a third of all PLWHA are Black (37.2%), while about five out of ten people with HIV/AIDS are White (50.8%). Based on the smaller number of Blacks in the general population, the HIV prevalence rate (705.4/100,000) is exceeding the rate of Hispanics (231.5/100,000) and Whites (104.3/100,000). HIV/AIDS continues to affect Black males disproportionably more than their White counterparts.

Each PLWHA is associated with a risk category of how they were most likely infected with the disease. The overwhelming majority self-identified as Men Having Sex with Men (MSM). Its rate of 170.9 per 100,000 people of the population is between 6 to 10 times higher than any other risk category for all diagnosed people. It is the single largest category of risk for all race and ethnicity groups, and it is especially pronounced for Blacks. Heterosexual risk is the second highest risk category at 32.4 per 100,000 people.

Geographically, the vast majority of people that were diagnosed in Indiana are also living here (88.8%). Within the state of Indiana, most PLWHA are concentrated in the urban areas of the State. The majority are living in Health Region 5, corresponding to Central Indiana and the Indianapolis Metropolitan area, with 311 per 100,000 diagnosed people. Other regions with large numbers of PLWHA include Region 1 (190/100,000) and Region 2 (137/100,000) which corresponds to the northern part of the state adjacent to Chicago, and Region 7 (137/100,000) located in Southwestern Indiana.

New Diagnosis:

In 2013, the number of newly diagnosed persons in Indiana was 498, slightly down from 2012, which had 509 newly diagnosed persons. The diagnosis rate remained relatively the same in 2013 at 7.7, slightly down from 7.9 per 100,000 population in 2012. The highest rate of new diagnosis occurred among males between the ages of 20 to 24 years of age. This is similar to 2012. Males continue to outrank females more than four times. The male diagnosis rate of 12.8/100,000 has slightly decreased from a rate of 12.9 in 2012. The female new diagnosis rate decreased to 2.7 from 2.9/100,000 in 2012.

For 2013, close to half of all diagnosed people are Black (50.2%), while in comparison the percentage of Whites shows a decrease (35.7%). The gap between races continues to show a shift in the populations affected as shown by the previous year, 2012 (47.7% Black vs. 40.1% White). Blacks continue to have a rate (42.3) that is three times the rate of Hispanics (11.8), and more than twelve times that of Whites (3.3). New diagnosis among males is predominant for all racial and ethnic groups. The rate of new diagnosis with HIV/AIDS among Black males (68.1) is especially high compared to their Hispanic (20.0) and White (5.8) counterparts. The majority of new diagnoses can be found in the MSM risk category, with a diagnosis rate of 8.0 per 100,000 population. The main contributors are Blacks (46.1%), Whites (40.2%), Hispanics (9.8%), and Other (3.9%). Heterosexual risk is the second highest category representing Blacks (55.8%), Whites (24.2%), and Hispanics (12.6%). Compared to 2012, Blacks and Whites showed a slight decrease, while Hispanics increased in the heterosexual risk category.

Geographically, nearly five out of ten newly diagnosed persons live in Health Region 5 in Central Indiana, while regions 1, 2, and 7 come in close seconds of one another. Within the leading regions, Marion County and Lake County had the most new diagnoses in the reported time period.

Mothers with HIV:

The cumulative number of reported cases of children born to HIV positive mothers, 1982 through 2013, in Indiana was 1,006, up from 937 in 2012. More than half of these children are Black (52.0%), less than one in three is White (29.7%), and almost a tenth are Hispanic (9.4%). Of all the children that were born to diagnosed mothers, 18.3% tested positive for HIV or were diagnosed with AIDS. Please note that these numbers are cumulative and include all children, including those that were born before medication to prevent the spread of the HIV virus from mother to child was available. These numbers also include foreign born children that have moved to Indiana. As of June 2014, there was 1 new 2013 pediatric HIV diagnosis reported based on case follow-ups.

Mortality:

The number of people that died of HIV/AIDS-related complications in Indiana peaked around the year 1995 and started to drop sharply thanks to the widespread availability of antiretroviral medications. However, in 2007, the number of persons that were diagnosed with HIV/AIDS and died was 210, up from 121 in 2006. The Office of Clinical Data and Research completed a death match in early 2008. The Vital Statistics department provides information on any

deaths of persons for a given time period which is used to match against the surveillance data base to identify persons with HIV/AIDS that have deceased. This may account for the increase in deaths associated with persons that have HIV/AIDS. From 2008-2009, the number dropped to 119 deaths. This decrease may in part be due to the development of a new Vital Records system established in early 2009. Many submitters were back logged with submittal of mortality reports. In 2010, it went back up to 149 deaths, which were later followed by 207 deaths in 2011. This is likely a result of another death match with Vital Records and a comparison with the National Death Index. The number of deaths recorded for 2012 during this report was at 139. In 2013, the majority of diagnosed people that died (173) were males (80.0%). Among the racial and ethnic groups, the death rate was highest for Whites (60.1%), followed by Blacks (34.7%) and Hispanics (1.2%). The highest number of deaths occurred among persons aged 50 to 59 (35.8%). The majority of deaths are connected to the MSM and Hetero risk group, with mortality percentages of 45.7% and 19.1% respectively. Geographically, the highest mortality percentage occurred in Region 5 (Central Indiana) at 45.1%.

Mobility:

Of the total number of diagnosed people in Indiana as of December 31, 2013, a relatively small number have migrated (11.2%). By the end of 2013, a cumulative total of 1,115 PLWHA that were diagnosed in Indiana had moved out of the state, compared to 1,040 in 2012. At the same time, a cumulative total of 2,648 PLWHA had moved into Indiana that were diagnosed by another state, compared to 2,377 persons in 2012. Of the diagnosed persons that moved into the state, the majority were White (48.3%), compared to 50.0% in 2012. Over one-third of all persons that moved to Indiana were Black (41.0%), up from 36.6% in 2012. Diagnosed persons of Hispanic ethnicity rose as a percentage of all persons moving to Indiana. They comprised 9.9% in 2013, compared to 8.2% in 2012. Of those that moved to Indiana, more than a third (40.0%) settled in central Indiana's Health Region 5, and 12.5% in Region 1, the northern part of the state. The rest were distributed more or less equally among the other health regions of the state.

Counseling and Testing:

In 2013, a total number of 17,369 HIV tests were administered in Indiana by the state, federally funded sites, compared to 16.357 in 2012. Out of those 17,369 tests, 121 (0.7%) had a positive result, similar to the numbers for 2012 (120/0.7%). Slightly more tests were administered to males (55.3%) than to females (44.4%). In addition, 39 tests were administered to Transgender persons (none positive). The positive test rates for males (10.2/1,000) were almost five times the number of female test results (1.8/1,000). Blacks (9.3) had a higher positivity rate per 1,000 tests as compared to Hispanics (5.2) and Whites (4.3). This changed from the previous year when rates among Whites (5.7) and Blacks (6.9) were closer. The largest number of positives came from the 20-29 age group (39.9%), with 30-39 year olds (21.1%) as a runner-up.

Youth Risk Behavior Survey:

The Youth Risk Behavior Survey (YRBS) surveys the health-risk behaviors of young people every two years in six domains: (1) behaviors which facilitate unintentional injuries and violence, (2) tobacco use, (3) alcohol and drug uses, (4) sexual behaviors related to pregnancy and sexually transmitted diseases, (5) unhealthy dietary behaviors, and (6) physical inactivity and being overweight. The information gathered from the 2009 YRBS reveals that three-quarters of adolescents have used alcohol and over a third had used marijuana. Almost half of adolescents in Indiana (49.2%) have had sexual intercourse, while about a third are currently sexually active. An encouraging 89.6% of Indiana adolescents have been taught about HIV infection in school, yet only 58.0% used a condom during the last sexual intercourse.

Behavioral Risk Factor Surveillance System:

In 2010, a survey (respondents=6,231) was conducted to assess the indicators of risk for HIV/AIDS in Indiana. The survey asked specific questions to a representative group of Indiana residents. Approximately 34.6% of all interviewees have ever been tested for HIV, down from 37.9% in 2009. Of those tests, the majority were done in a hospital (41.1%) or a private doctor/HMO (40.4%). Respondents with a higher percentage of HIV testing were more likely to be among the 25-34 and 35-44 age groups (47.6% vs. 45.2%). Blacks have the largest share of HIV tests among each racial and ethnic group with 60.9%. However, only 30.5% of men had been tested for HIV compared to 38.8% of women. A higher percentage of respondents (43%) with an income of $24,999 or less indicated they have been tested for HIV.

STD:

In 2013, Chlamydia continued to be the most frequently reported sexually transmitted disease (STD) in Indiana, with 28,023 reported cases, 29,505 cases in 2012, and 27,801 in 2011. The majority of cases identified as White (46.7%) and Black (36.4%). Gonorrhea cases in 2013 were reported at 7,144 cases, 7,338 in 2012 and 6,569 in 2011. The majority of cases identified as Black (55.8%) and White (33.0%). Primary and secondary syphilis was reported to be 215 in 2013, down from 224 in 2012, and up from 173 reported cases the year prior. The majority of cases identified as Black (41.4%) and White (43.3%). Females continued to outnumber males for both Chlamydia and gonorrhea while syphilis is more prevalent among males. The majority of cases for Chlamydia and gonorrhea are among those <= 24 years of age. For Primary and secondary syphilis the majority of cases goes up to <= 29 years of age.

Hepatitis and TB:

In 2013, Indiana had 104 cases of acute Hepatitis B, greater than 88 in 2012. The total number of chronic Hepatitis C infections for the state was reported to be 4,535 cases in 2013. Finally, 94 cases of Tuberculosis (TB) were reported in Indiana in 2013, down from 103 in the previous year. Of those 94 TB cases two persons were also HIV positive.

Care Issues:

In the fiscal year that ran from April 1, 2012 to March 31, 2013, the funding for Part B of the Ryan White CARE Act added up to a total of $11,923,142. The majority of that budget (88%) financed the AIDS Drug Assistance Program (ADAP) and the Health Insurance Assistance Program (HIAP), while the rest was used for other administrative costs.

Of the 67 persons enrolled in ADAP in the same period, more than half (48.75%) were White. The share of Blacks among ADAP recipients remained stable at 40.3%. The majority of recipients (62.7%) continued to select MSM as their main risk category. In this report period, 2,488 persons were enrolled and received assistance through HIAP, an increase of 13.86% compared to 2,185 a year prior.

As of March 31, 2013, Indiana had a prevalence of 10,795 PLWHA. Annually, the HIV Care Services program uses the total PLWHA to estimate an Unmet Need population. Unmet Need is defined as service needs and gaps for diagnosed individuals who know their HIV positive status and are not receiving primary care. To calculate this estimation, persons found to have a CD4 or viral load test between April 1, 2012 and March 31, 2013 were identified as receiving care based on records kept by the electronic HIV AIDS Reporting System (eHARS). Also, individuals found to have Medicaid service or antiretroviral drug claims within this time frame were determined to be in care. Persons with the requirements listed above were removed and as a result, 3,529 (32.7%) PLWHA were found to represent those with Unmet Need. Demographically, Whites represented 46.0%, Blacks represented 40.0%, and Hispanics represented 10.0% of the Unmet Need population. Most persons fell into the 40 – 49 age groups (35.0%). Of those with Unmet Need, a higher percentage of persons identified as Homosexual (45.0%) while Heterosexual (16.0%) and IDU (5.0%) followed.

Purpose of the Jurisdictional HIV Prevention Plan

The Purpose of the Jurisdictional HIV Prevention Plan (Plan) is to provide a blueprint for HIV planning and provide flexible direction. The Plan is structured to:

1. Support the implementation of High-Impact Prevention programs;
2. Ensure that HIV planning is efficient and focused on results-oriented processes;
3. Encourage collaboration and coordination across HIV prevention, care and treatment services;
4. Reduce reporting documentation;
5. Engage a broader group of stakeholders; and
6. Focus on streamlining communication, coordination and implementation of needed services, including mental health and substance abuse, across the continuum of HIV prevention, care and treatment services

The Indiana State Department of Health and HIV Prevention Community Planning Group has chosen to update the existing plan for one year since we intend to create a combined 4-year plan with Comprehensive HIV Services Planning and Advisory Council thereafter in 2016 and update the plan annually or as needed.

Indiana State Department of Health
HIV Prevention Programs

HIV prevention is the best strategy for reducing the human and economic toll from HIV/AIDS. Comprehensive HIV prevention is a broad term that incorporates tracking the epidemic through HIV/AIDS Surveillance system, research to identify causes and solutions, implementing effective, evidence based prevention intervention programs; building capacity of state and local programs; and program evaluation and policy development.

The goal of the Indiana HIV Prevention Program is to increase public understanding of, involvement in, and support for HIV prevention in an effort to reduce the number of new infections. The focus is on eliminating racial and ethnic disparities in new infections and prevention with HIV-positive individuals. Programs are implemented statewide through designated health departments and community based organizations (CBOs). These agencies provide education, information, and services to initiate modification of behavior patterns or practices that put persons at risk for HIV infection. Targeted populations include teenagers, men who have sex with men, women at risk (including pregnant women), substance users, needle sharers, prisoners, and individuals from racial and ethnic populations which are disproportionately affected by HIV Disease and others at risk.

Adult Viral Hepatitis Prevention
The mission of this program is to decrease transmission of hepatitis viruses, increase hepatitis A & B immunizations among adults and those at increased risk, increase resources to identify and treat persons with chronic hepatitis, increase identification of those living with viral hepatitis and increase awareness among healthcare providers and laboratories as to their roles in prevention, detection, management, and treatment of viral hepatitis.

Perinatal Hepatitis B Prevention Program (PHBPP)
The Indiana Perinatal Hepatitis B Prevention Program (PHBPP) is a resource for the surveillance and control of perinatal hepatitis B infection. The primary goal of the program is to prevent perinatal transmission of hepatitis B infection by identifying and providing case management to HBsAg-positive pregnant women to ensure initiation of post-exposure prophylaxis to their newborns.

Perinatal HIV Project
The Perinatal HIV Project provides consultation, education, training and technical assistance to healthcare providers, women and consumers regarding HIV counseling, and testing to pregnant women and the prevention identification and care for women with HIV and their infants. The One Test Two Lives: Prevent HIV Indiana campaign is an effort of multiple partners to increase awareness and promote practices that will result in prevention of HIV transmission from mothers to their babies. The campaign is a multi-pronged outreach designed for those who provide care to and interact with women of childbearing age and the general public to make sure everyone is knowledgeable regarding mother-to-child-transmission of HIV. In addition to providing this education firsthand to those that the campaign has the ability to reach, it is also an objective to ask those who receive this important message to join in the prevention efforts.

Capacity Building Assistance Program

The goal of the Capacity Building Assistance program is to improve the performance of Indiana's HIV prevention workforce in the following areas: Strengthening Organizational Infrastructure, Strengthening Interventions for HIV Prevention, Strengthening Community Access to and Utilization of HIV Prevention Services, and Strengthening Community Planning for HIV Prevention. This is done by assisting community based organizations and local health departments to increase and sustain their ability to deliver effective HIV prevention services. Once a need has been identified, program staff initiates a request for local and national providers to assist with meeting the provider's capacity building needs.

Training and Development Program

This program initiates, coordinates, and provides trainings related to HIV prevention. These trainings are provided by program staff as well as through collaborations with national providers. The program holds monthly HIV Prevention Counseling Certification Training for employees and volunteers of community partners.

Needs Assessment and Gap Analysis

Needs Assessment
Needs assessment is the process of obtaining and analyzing findings to determine the type and extent of unmet needs in a particular population or in a community.

Gap Analysis
A gap analysis is used to identify and describe the gaps in services for defined high-risk populations determined by the needs assessment. A gap analysis is usually conducted following any needs assessment activities that have taken place. The needs assessment committee then utilizes this document in order to make recommendations to the state of Indiana.

As a result of these activities, the ISDH and CPG have identified the following populations to watch: black heterosexual men, commercial sex workers, Hispanic women, injection drug users (IDU) and transgender persons. The numbers of new HIV infections for these groups is on the rise locally. These groups have been shown to be at extremely high risk in the United States. They also have unique needs in regard to HIV prevention services.

Additional work is needed in this area to more fully identify needs and gaps with regard to HIV prevention, care and services in the state of Indiana. The CPG, in partnership with the Division, Indiana Minority Health Coalition and Policy Resource Group, LLC, created *Moving Forward Together: A Needs Assessment Research Agenda for HIV Prevention in Indiana*, *http://www.indianacpg.org/Upload/Uploaded_Information_for_Website/Moving_Forward_Together_HIV_Prevention_Research_Agenda_May_2010_final.pdf*. This agenda will guide future needs assessment work in the state.

HIV Prevention Resources

Counseling, Testing, and Referral (CTR) Program

The mission of this statewide program is to provide and facilitate disease intervention and prevention. This is accomplished through counseling, testing, and client referrals to other service needs. This program also serves to promote early detection of HIV infection and facilitate access to health care. This will be done through collaboration between agencies that have been funded to provide HIV prevention and services. According to the CDC, testing is one of the several critical services needed to get people into care. Providing linkage to services when and where HIV screening services are provided to help overcome barriers to obtaining care is essential. This statewide program coordinates the efforts of local HIV counseling and testing sites. The goal of the program is to prevent HIV transmission. It also serves to promote early detection of HIV infection and facilitate access to health care. The program ensures that partners have the opportunity to implement prevention strategies while gaining access to counseling, testing, and other services as appropriate.

Counseling, Testing and Referral (CTR)

The CDC estimates that more than 1.2 million adults and adolescents in the United States are living with HIV and many are unaware of their infection. The primary purpose of CTR is to increase clients' knowledge of their HIV status; encourage and support risk reduction; and secure needed referrals for appropriate services (medical, social, prevention, and partner services).

There are crucial activities that may be tailored to fit different agencies and at-risk populations. These are parts of the strategy that can be adapted to meet the needs of the organization or target population:

1. Provide information and education about testing in 1 of 3 ways:
   a. Individual session
   b. Small or large group sessions.
   c. Brochures, handouts, videos, or audiotape, or other non-personalized information.
2. Deliver client-focused counseling and test results in an individual, face-to-face session.
3. Use a variety of specimen types and test types for HIV antibody testing, depending on the setting in which testing is conducted and the needs of the organization and the client.
4. Provide service referrals to client's self-identified priority needs (increases likelihood that referrals will be completed), if possible.
5. For clients whose test results are positive, priority is placed on referrals for medical care, partner services**,** and other prevention and support services.

Partner Services (PS)

The goal of PS is to notify the sex and/or needle-sharing partners, including spouses, of HIV-infected individuals of their possible exposure to HIV and to recommend that they seek health care to include counseling and testing. The goal of this is to help prevent HIV transmission and to ensure that partners have the opportunity to implement prevention strategies while gaining access to counseling, testing, and other services as appropriate.

Comprehensive Risk Counseling and Services (CRCS) Program
The goal of CRCS is to promote the adoption and maintenance of HIV risk-reduction behaviors by clients who have multiple, complex problems and risk-reduction needs. The ISDH has set the following guidelines for those individuals who should be referred to this public health strategy:

1. Any HIV-negative client who presents for repeated testing with no signs of change in behavior.
2. Any HIV-positive client who demonstrates an unwillingness to adhere to the "duty to warn" law.
3. Any client who demonstrates an unwillingness to engage in some level of risk reduction behavior.
4. Any client who is in a serodiscordant relationship and expresses a desire to learn more about transmission prevention or is putting him/herself or his/her partner at risk.
5. Any client who reports wanting or needing assistance or additional support to make behavior change associated with risk.
6. Any client who reports having been diagnosed with two or more sexually transmitted infections in the last 12 months.

This public health strategy provides several sessions of client-centered HIV risk-reduction counseling. CRCS helps clients initiate and maintain behavior change toward HIV prevention while addressing competing needs that may make HIV prevention a lower priority. This strategy addresses the relationship between HIV risk and other issues such as substance abuse, mental health, social and cultural factors, and physical health.

CRCS has the following 7 Core elements:

1. Provide CRCS as intensive, client-centered HIV risk-reduction counseling, and include conventional case management services only when the client does not have access to those services.
2. Base CRCS services on the premise that some people may not be able to prioritize HIV prevention when they face problems perceived to be more important and immediate.

For HIV-positive individuals

3. Focus on persons living with HIV who have multiple, complex problems and risk-reduction needs who are having, or are likely to have, difficulty initiating or sustain practices that reduce or prevent HIV transmission.

For HIV-negative individuals

4. Consider persons whose HIV status is negative or unknown to be eligible if they have a recent history (past 6 months) of 1 or more of the following:
    - unprotected sex with a person who is living with HIV.
    - unprotected sex in exchange for money or sex.
    - multiple (e.g., more than 5) or anonymous sex partners.
    - multiple or anonymous needle-sharing partners.
    - a diagnosis of a sexually transmitted disease.

5. Recruit persons who expressed some degree of commitment to participating in ongoing risk-reduction counseling.
6. Hire prevention counselors with the appropriate training and skills to complete the CRCS activities within their job description.
7. Develop clear procedures and protocol manuals for the CRCS program to ensure effective delivery of CRCS services and minimum standards of care.

Evidence-Based Behavioral Interventions

- **Mpowerment** is a community building program designed to reduce the frequency of unprotected anal intercourse among young gay and bisexual men ages 18–29. The Mpowerment intervention is based on an empowerment model in which young gay men take charge of the project. The project draws on the theory of diffusion of innovations, which suggests that people are most likely to adopt new behaviors that have already been accepted by others who are similar to them and whom they respect.
- **Healthy Relationships** is a multisession, small-group, skills-building program for men and women living with HIV/AIDS. The program is designed to reduce participants' stress related to safer sexual behaviors and disclosure of their serostatus to family, friends, and sex partners. The program is based on Social Cognitive Theory, which states that persons learn by observing other people successfully practice a new behavior.
- **Popular Opinion Leader (POL)** is an intervention based on a program that identifies, trains, and enlists the help of key opinion leaders to change risky sexual norms and behaviors in the gay community. The target population is men who frequent gay bars. The program is based on diffusion of innovation/social influence principles, which states that trends and innovations are often initiated by a relatively small segment of opinion leaders in the population. Once innovations are visibly modeled and accepted, they then diffuse throughout a population, influencing others.
- **VOICES/VOCES** is a single-session, video-based HIV/STD prevention program designed to encourage condom use and improve condom negotiation skills. The target population is African-American and Latino adult men and women clinic clients. The program is based on the theory of reasoned action, which explains how behaviors are guided by attitudes, beliefs, experiences, and expectations of other persons' reactions. VOICES/VOCES is grounded in extensive formative research exploring the culture- and gender-based factors that can facilitate behavior change.

***For a list of 2015 HIV Prevention Service Providers, see Appendix A*.**

Expanded HIV Testing in Medical Settings Program

In September 2007, Wishard Hospital, (now known as Eskenazi Hospital) an urban inner city hospital located in Indianapolis, began collaborating with Midwest AIDS Training and Education Center (MATEC) to create a combined task force comprised of hospital staff, representatives from community based organizations, and ISDH in an effort to implement an Emergency Department (ED) based routine HIV screening pilot project. Execution of routine HIV testing in the Wishard (Eskenazi) ED began in September of 2008, and expanded to Blackburn Community

Health Center in Marion County in August of 2012. The Methodist Hospital in Lake County began ED testing in the Fall of 2012.

Special Populations Support Program (SPSP)
The Special Populations Support Program (SPSP) provides intensive support services to individuals diagnosed with HIV disease and chemical dependency. It also conducts HIV testing in treatment facilities sanctioned by the Department of Mental Health and Addictions (DMHA). Additional testing for Hepatitis C and other sexually transmitted diseases is conducted when risks are indicated.

The Special Populations Support Program (SPSP) is designed to deliver two distinct but complementary services: disease prevention and supportive care. SPSP employs certified HIV testing counselors who have been specially trained to perform comprehensive risk assessments, pre-test counseling, testing, and post-test counseling with the substance using population. The testing counselors conduct their testing activities in a variety of venues where the target population can be found, including the statewide DMHA treatment facilities.

HIV positive individuals are then referred to the program's support specialists who engage the consumer with interventions designed to minimize substance use and maximize compliance with all applicable treatment plans. The specialists work closely with the local HIV Care Coordination agency to ensure that the consumer receives comprehensive care.

For a list of 2015 SPSP Service Providers, see Appendix B

HIV Care Resources

Care Coordination Program

All persons testing HIV-positive who receive their test results at an ISDH sponsored facility are referred to the HIV Care Coordination Program. HIV Care Coordination is a specialized form of HIV case management. Its mission is to assist those living with HIV disease with the coordination of a wide variety of health and social services. Case Management services are available statewide at 16 regional sites (***for a list of current Care Coordination service providers, see Appendix C***). Care Coordination provides an individualized plan of care that includes medical, psychosocial, financial, and other supportive services, as needed. Care Coordination services are offered free of charge.

The primary goals of the program are to ensure the continuity of care, to promote self-sufficiency, and to enhance the quality of life for individuals living with HIV. Care Coordinators are trained professionals who can offer assistance in the following areas:

- Access to health insurance to obtain medications, including Medicaid, Medicare, Early Intervention Plan (EIP), AIDS Drug Assistance Plan (ADAP), Health Insurance Assistance Plan (HIAP), Indiana Comprehensive Health Insurance Association (ICHIA), Health Advantage, and the Ryan White Program (Parts A & C) offered through the Marion County Health Department, etc.;
- Access to housing programs such as Section 8, Housing Opportunities for Persons with AIDS (HOPWA), Shelter Plus Care, etc.;
- Access to emergency funds, such as Direct Emergency Financial Assistance (DEFA) to assist with rent, utilities, medications, etc.;
- Access to mental health and substance abuse programs;
- Referrals for optical and dental care;
- Referrals to community and government programs, such as Social Security;
- Referrals to local food pantries;
- Referrals to support groups;
- Referrals for legal assistance;
- Assistance with medication management and adherence;
- Assistance with transportation (e.g., bus passes);
- Access to HIV testing and prevention counseling services; and
- Access to HIV prevention and education services.

A referral for medical care is usually made following a full assessment of the client's needs and resources. Like all referrals made by the HIV Care Coordinator, those for medical care are closely monitored to ensure successful completion. HIV Care Coordination staff reminds clients of upcoming appointments, confirm that transportation arrangements have been made, and immediately evaluate the success of the referral through direct contact with the client. In the event of incomplete or unsuccessful referrals, alternate arrangements can be made for the client.

HIV Medical Services Program

The HIV Medical Services Program provides assistance to individuals with HIV disease in need of therapeutic medications and medical services. It is designed to give an individual full access to comprehensive health insurance at no cost to the person enrolled in the program. The program provides both short- and long-term benefit packages covering basic health care services as well as the range of HIV-related medical services and medications, including all FDA-approved highly active antiretroviral drugs. Four different plans are offered:

- **Health Insurance Assistance Plan (HIAP)**
  This program pays the premium, deductible, co-pay and co-insurance costs to eligible individuals routed through participating Indiana Qualified Health Plans.
- **AIDS Drug Assistance Plan (ADAP)**
  This program assists eligible individuals in obtaining limited FDA-approved therapeutic drugs if there is a waiting period before HIAP insurance coverage begins.
- **Early Intervention Plan (EIP)**
  This program covers the costs associated with medical services such as doctor visits, laboratory services, specified vaccinations, and influenza shots. EIP provides funding for health care services during a waiting period before HIAP insurance coverage begins
  Medicare Part D Assistance Plan (MDAP)
  This program provides assistance toward the co-pay, co-insurance and deductible cost of a Medicare Part D prescription drug plan for qualifying individuals

HIV Prevention Community Planning Group

The Indiana HIV Prevention CPG is comprised of persons throughout the state of Indiana who are either infected with or affected by HIV/AIDS. The CPG works in partnership with the ISDH Division of HIV/STD/Viral Hepatitis (Division), HIV Prevention Program to monitor this Jurisdictional HIV Prevention Plan that best represents the needs of various communities at risk for or infected with HIV. The Indiana HIV Prevention CPG allows for a membership of 25 persons. Applications are accepted throughout the year with new members selected on an annual basis, during the month of October. Technical advisors are provided by the Division and recruited from associated fields. The CPG has the responsibility of reviewing the Epidemiological Profile, assessing community services, creating and submitting the letter of concurrence/non-concurrence/concurrence with reservations and evaluating planning activities. These tasks are completed by the following CPG committees: Executive Committee, Evaluation Committee, Membership Committee, and Engagement Committee. In addition to these committees there are Ad Hoc committees that focus on the following topics: Advocacy/Social Media, Policies and Procedures, and Sexually Transmitted Disease.

For a description of these committees, see Appendix D.

History of HIV Prevention Community Planning

In 1993, CDC issued a directive for *"states and localities"* to receive special funds for HIV prevention to assist in the creation of HIV Prevention Community Planning Groups (CPG). Prior to 1993, communities were involved in carrying out HIV prevention services, but were not involved in the planning of comprehensive state and local prevention programs. Decisions regarding HIV prevention were either mandated by Congress or administered by the CDC through its Cooperative Agreement with State Health Departments regulating their grantees to adhere to CDC mandated criteria. Community Planning was developed to reflect the belief that it would bring state and local health departments down to community level and assist them with a more realistic point of view for determining how best to respond to local HIV prevention priorities and needs. Community Planning also assists in giving these entities a vehicle to determine how the CDC's mandates and initiatives could be best carried out through local community decision making.

The Relevance of HIV Planning

The National HIV/AIDS Strategy (NHAS) is the driving force for combating the epidemic. It is estimated that 12.8 percent of people living in the United States are unaware of their HIV infection. It is critical that HIV planning be strengthened as a component in implementing the NHAS in Indiana. The collaboration of Indiana State Department of Health, community partners and stakeholders will result in the development and implementation of the engagement process and the jurisdictional plan, the execution of HIP program and activities and the achievement of the goals of NHAS.

Key Concepts of HIV Planning
Indiana HIV planning efforts will be guided by the five components of HIP:

- Effectiveness and cost
- Feasibility of full-scale implementation
- Coverage in the target population
- Interaction and targeting of interventions
- Emphasizing interventions that will have the greatest overall potential to reduce HIV infections

Importance of HIV Prevention Community Planning
CDC expects HIV prevention community planning to improve HIV prevention programs by strengthening the scientific basis, community relevance, and risk-based focus of HIV prevention interventions in each project area. The basic intent of the process has been threefold:

1. To increase meaningful community involvement in prevention planning
2. To improve the scientific basis of program decisions
3. To target resources to those communities at highest risk for HIV transmission/acquisition

The CPG will strive to engage a range of providers that cover the syndemics which co-occur with HIV and ensure that all CPG activities aim to reach the goals of the Indiana Jurisdictional plan and NHAS. The CPG will consider health inequities driving the epidemic, diversity of representation and communities that are most affected.

CPG members have a responsibility to ensure that HIV planning is truly a participatory process. CPG members are expected to participate in scheduled meetings and devote a number of hours to CPG-related activities.

Letter of Concurrence, Concurrence with Reservations or Non-Concurrence
The CPG will inform and review the Jurisdictional HIV Prevention Plan and submit a letter to CDC signed by the CPG co-chairs on behalf of the CPG membership. The letter can be one of concurrence, concurrence with reservations, or non-concurrence and will be submitted with the Jurisdictional HIV Prevention Plan. The letter will document the extent to which the CPG informed or did not inform the development of the Jurisdictional HIV Prevention Plan, a description of the process used to review the Jurisdictional HIV Prevention Plan, and whether or not the CPG concurs with the Jurisdictional HIV Prevention Plan developed by ISDH. In the case of concurrence with reservations, the letter will provide in detail the reason(s) why the group is submitting a concurrence with reservations. If the CPG does not concur, the letter will provide in detail the reason(s) why the group is submitting a non-concurrence.

APPENDIX A
PREVENTION FUNDED SITES
2015

AGENCY		INTERVENTIONS	COUNTIES SERVED
AIDS MINISTRIES/AIDS ASSIST		Counseling, Testing and Referral Services (CTR)	Cass, Elkhart, Fulton, LaPorte, Marshall, Miami, Pulaski, St. Joseph, Starke
201 South William Street **South Bend, IN 46601**	**Phone 574-234-2870** **Fax 574-232-2872**		
616 South Main Street **Elkhart, IN 46516**	**Phone 574-293-9743** **Fax 574-294-8673**		
AIDS RESOURCE GROUP		Counseling, Testing and Referral Services (CTR) Comprehensive Risk Counseling and Services (CRCS)	Daviess, Dubois, Gibson, Knox, Martin, Perry, Pike, Posey, Spencer, Vanderburgh, Warrick
201 NW 4th Street **Suite B-7** **Evansville, IN 47708**	**Phone (812) 421-0059** **Fax (812) 424-9059**		
ALIVENESS PROJECT		Counseling, Testing and Referral Services (CTR) Comprehensive Risk Counseling and Services (CRCS)	Lake, Porter, Newton, Jasper
5490 Broadway **Suite L-3** **Merrillville, IN 46401**	**Phone 219-985-6170** **Fax 219-985-6097**		
BROTHERS UNITED		Counseling, Testing and Referral Services (CTR) Comprehensive Risk Counseling and Services (CRCS) Many Men, Many Voices (3MV)	Daviess, Dubois, Gibson, Knox, Martin, Perry, Pike, Posey, Spencer, Vanderburgh, Warrick
3737 N. Meridian Street **Indianapolis, IN 46208**	**Phone 317-931-0292** **Fax 317-931-0294**		
CLARK COUNTY HEALTH DEPARTMENT		Counseling, Testing and Referral Services (CTR)	Clark, Crawford, Dearborn, Floyd, Harrison, Jefferson, Ohio, Orange, Ripley, Scott, Switzerland, Washington
1301 Akers Avenue **Jeffersonville, IN 47130**	**Phone 812-283-2586** **Fax 812-288-1474**		
DAMIEN CENTER		Counseling, Testing and Referral Services (CTR) Comprehensive Risk Counseling and Services (CRCS)	Boone, Hamilton, Hancock, Hendricks, Johnson, Marion, Morgan, Shelby
26 North Arsenal Avenue **Indianapolis, IN 46201**	**Phone 317-632-0123** **Fax 317-632-4362**		
ELKHART COUNTY HEALTH DEPARTMENT		Counseling, Testing and Referral Services (CTR)	Cass, Elkhart, Fulton, LaPorte, Marshall, Miami, Pulaski, St. Joseph, Starke
608 Oakland Avenue **Elkhart, IN 46516**	**Phone 574-523-2130** **Fax 574-523-2163**		

AGENCY		INTERVENTIONS	COUNTIES SERVED
ESKENAZI HEALTH HOSPITAL		Expanded HIV Testing	Marion
Emergency Department Lower Level 720 Eskenazi Avenue Indianapolis, IN 46202	**Phone 317-880-7990**		
ESKENAZI HEALTH CENTER BLACKBURN			
2700 Dr. Martin Luther King Jr. Street Indianapolis, IN 46208	**Phone 317-931-4300**		
FORT WAYNE/ALLEN COUNTY HEALTH DEPARTMENT		Comprehensive Risk Counseling and Services (CRCS)	Adams, Allen, DeKalb, Huntington, Kosciusko, LaGrange, Noble, Steuben, Wabash, Wells, Whitley
4813 New Haven Avenue Fort Wayne, IN 46803	**Phone 260-449-3021 Fax 260-449-3507**		
CONNECTIONS COUNSELING			
615 West Foster Parkway Fort Wayne, IN 46807	**Phone 260-403-3961 Fax 260-700-3714**		
IMANI UNIDAD		Comprehensive Risk Counseling and Services (CRCS)	Cass, Elkhart, Fulton, LaPorte, Marshall, Miami, Pulaski, St. Joseph, Starke
914 Lincolnway West South Bend, IN 46616	**Phone 574-288-2887 Fax 574-288-2891**		
METHODIST HOSPITAL NORTHLAKE		Expanded HIV Testing	Lake
600 North Grant Street Gary, IN 46402	**Phone 219-886-4710**		
METHODIST HOSPITAL SOUTHLAKE			
8701 Broadway Merrillville, IN 46410	**Phone 219-738-5887**		
OPEN DOOR HEALTH SERVICES		Comprehensive Risk Counseling and Services (CRCS)	Blackford, Cass, Delaware, Grant, Howard, Jay, Madison, Miami, Randolph, Tipton
905 South Walnut Street Muncie, IN 47302	**Phone 765-281-4263 Phone 765-748-8274 (Cell Phone)**		
POSITIVE LINK		Counseling, Testing and Referral Services (CTR) Comprehensive Risk Counseling and Services (CRCS)	Clay, Greene, Owen, Parke, Putnam, Sullivan, Vermillion, Vigo, Bartholomew, Brown, Jackson, Jennings, Lawrence, Monroe
333 East Miller Street Bloomington, IN 47401	**Phone 812-353-3250 or 1-800-245-0261 Fax 812-353-3226**		
BOOKER T. WASHINGTON CENTER		Counseling, Testing and Referral Services (CTR)	Vigo
1101 South 13th Street Terre Haute, IN 47802	**Phone: 812-353-3230**		

AGENCY		INTERVENTIONS	COUNTIES SERVED
POSITIVE RESOURCE CENTER		Outreach Counseling, Testing and Referral Services (CTR)	Adams, Allen, DeKalb, Huntington, Jay, Kosciusko, LaGrange, Noble, Steuben, Wabash, Wells, and Whitley Free HIV Testing in these counties
525 Oxford Street **Ft. Wayne, IN 46806**	**Phone 260-744-1144** **Fax 260-745-0978**		
STEP-UP, INC		Popular Opinion Leader	Boone, Hamilton, Hancock, Hendricks, Johnson, Marion, Morgan, Shelby
850 North Meridian St. **Indianapolis, IN 46204**	**Phone 317-258-7013** **Fax 317-259-7034**		
WAYNE COUNTY HEALTH DEPARTMENT		Counseling, Testing and Referral Services (CTR) Counseling, Testing and Referral Services (CTR)	Blackford, Cass, Decatur, Delaware, Fayette, Franklin, Grant, Henry, Howard, Jay, Madison, Miami, Randolph, Rush, Tipton, Wayne, Union
203 East Main Street **Richmond, IN 47374**	**Phone 765-973-9294** **Fax 765-973-9233**		
HEARTLAND COMMUNITY SERVICES, INC.			
520 West Main **Muncie, IN 47305**	**Phone 765-702-9724**		

APPENDIX B
SPECIAL POPULATIONS SUPPORT PROGRAM ~ DIRECTORY
2015

AIDS ASSIST 201 South William Street South Bend, IN 46601 (574)234-2870 ext. 1103 or (800)388-2437 (574)232-2872 fax	**CLARK COUNTY HEALTH DEPARTMENT** 1301 Akers Ave. Jeffersonville, IN 47130 (812)283-2586 (812)288-1474 fax
AIDS RESOURCE GROUP 201 NW 4th Street, Suite B7 Evansville, IN 47708 (812)421-0059 or (800)423-6255 (812)424-9059 fax	**FT WAYNE / ALLEN COUNTY HEALTH DEPT.** 4813 New Haven Ave. Fort Wayne, IN 46803 (260)449-3021 (260)449-3507 fax
ALIVENESS PROJECT 5490 Broadway, Suite L3 Merrillville, IN 46410 (800)293-7312 or (219)985-6097 fax	**INDIANAPOLIS URBAN LEAGUE** 777 Indiana Avenue Indianapolis, IN 46202 (317)693-7603 (317)693-7613 fax
ASPIRE INDIANA – CENTRAL 2009 Brown St. Anderson, IN 46016 (765)641-8326 ext. 4528 (765)608-5541 fax Counties served: Cass, Howard, Madison, Miami and Tipton	**IU HEALTH – POSITIVE LINK** (serving Bloomington) 333 East Miller Drive Bloomington, IN 47401 (812)353-3254 or (812)353-3269 (800)245-0261 or (812)353-3226 fax
ASPIRE INDIANA – EAST Abby Judson (1 FTE) 2809 W. Godman Suite 5 Muncie, IN 47304 (765)286-4481 Counties served: Blackford, Delaware, Grant, Jay And Randolph	**IU HEALTH – POSITIVE LINK** (serving Terre Haute) 333 East Miller Drive Bloomington, IN 47401 (800)313-4645 or (812)353-3226 fax
ASPIRE INDIANA – SOUTHEAST 600 E. Main St. L-14 Mailing address P O. Box 341 Richmond, IN 47374 (765)962-8778 Counties served: Decatur, Fayette, Henry, Ripley, Rush Union and Wayne	**POSITIVE RESOURCE CENTER** 525 Oxford Street Fort Wayne, IN 46806 Phone (260)744-1144 or –(800)417-3085 (260)745-0978 fax
ASPIRE INDIANA – WEST 133 N. 4th Street ,Suite 409 Lafayette, IN 47901 (765)742-4402 Counties served: Benton, Carroll, Clinton, Fountain, Jasper, Montgomery, Newton, Tippecanoe, Warren and White	

APPENDIX C
2015 CARE COORDINATION PROVIDERS

SITE	LOCATION	TELEPHONE
AIDS Assist	201 South William Street **South Bend**, IN 46601	574/234-2870 800/388-2437
Satellite	616 South Main Street **Elkhart**, IN 46516	574/293-9743 **574/294-8673 fax**
AIDS Resource Group of Evansville	201 NW 4th Street, Suite B-7 **Evansville**, IN 47708	812/253-2047 **812/424-9059 fax**
Aliveness Project of Northwest Indiana	5490 Broadway, Suite L-3 **Merrillville**, IN 46410-0568	219/985-6170 **219/985-6097 fax**
Satellite	301 East 8th Street **Michigan City**, IN 46360	219/873-1250 800/290-2293
Aspire Indiana – Central	2009 Brown Street **Anderson**, IN 46016	765/641-8326, x4528 **765/442-0084 fax**
Aspire Indiana – Southeast	600 East Main Street, Suite L-14 **Richmond**, IN 47374	765/962-8742 **765/962-8347 fax**
Aspire Indiana – West	1231 Cumberland Ave., Suite C, **West Lafayette**, IN 47906	765/742-4481 **765/429-5914 fax**
Clark County Health Department	1301 Akers Avenue **Jeffersonville**, IN 47130	812/288-2706 800/828-5624
Concord Center Association	1310 South Meridian Street **Indianapolis**, IN 46225	317/637-4376 **317/637-4380 fax**
Damien Center	26 North Arsenal Avenue **Indianapolis**, IN 46201	317/610-8012 800/213-1163
Brothers United Satellite	3737 N Meridian St, Suite 505 **Indianapolis,** IN 46208	(317) 931-0292 **317/931-0294 fax**
Community Infectious Disease Satellite	7250 Clearvista Dr, Suite 260 **Indianapolis,** IN 46256	317/621-1690 **317/621-1699 fax**
Riley Hospital for Children Satellite	705 Riley Hospital Dr. **Indianapolis**, IN 46202	317/944-7260 **317/948-0860 fax**
Eskenazi Health	Infectious Disease Clinic 720 Eskenazi Ave. Fifth Third Bank Office Building, Fl 2 **Indianapolis**, IN 46202	317/880-3503 **317/880-0323 fax**
LifeCare – Indiana University Health	1633 N. Capitol Avenue, Suite 300 **Indianapolis**, IN 46202	317/962-2700 **317/963-5039 fax**
Meridian Health Services Corporation	240 North Tillotson **Muncie**, IN 47304	765/288-1928 **765/741-0340 fax**
Positive Link – IU Health Bloomington	333 East Miller Drive **Bloomington**, IN 47401	812/353-3241 800/313-4645 **812/353-3226 fax**
	1102 S 13th Street **Terre Haute,** IN	812/353-3229 **812/353-3226 fax**
Positive Resource Center (formerly known as AIDS Task Force)	525 Oxford Street **Fort Wayne**, IN 46806	260/744-1144 800/417-3085 **260/745-0978 fax**
Step Up Incorporated	850 N. Meridian Street **Indianapolis**, IN 46204	317/259-7013, x16 **317/259-7034 fax**

APPENDIX D

HIV PREVENTION COMMUNITY PLANNING GROUP
COMMITTEE DESCRIPTIONS

Advocacy Ad Hoc Committee

Advocacy/Social Media Committee shall consist of CPG members, one (1) HD technical advisor, and one (1) committee chair.

Ensure social media/networking tools (i.e. Facebook, Twitter, YouTube, other relevant blogs) are kept up-to-date;

1. Information contained on websites should be truthful and not misleading or deceptive.
2. Information should be accurate and concise.
3. Inappropriate communication with other users is prohibited.
4. All social media password(s) shall be kept private between the Committee and CPG Co-chair

Executive/Budget Committee

Executive Committee shall consist of the Community and HD Co-chairs, the chairpersons of each standing committee, and one (1) at-large new member voted on by the CPG members.

1. Prepare and approve the meeting CPG agenda;
2. Assist in identifying solutions for unresolved issues and conflicts;
3. Attend and participate in scheduled meetings of the body and the execute meetings;
4. Review CPG budget and finances;
5. Exhibit knowledge of CPG operations; and
6. Review membership applications submitted by the membership committee.

Engagement Committee

Engagement Committe*e* shall consist of CPG members, one (1) HD technical advisor, and one (1) committee chair.

1. Create an engagement process to improve a more collaborative approach to HIV prevention, interventions, services and treatment for the populations at the highest risk of acquiring or transmitting HIV;
2. Assess and identify the needs of the community related to HIV prevention, services, and treatment;
3. Determine the priority populations with the highest disease burden identified in the HD's epidemiology report;
4. Identify (traditional/nontraditional) key stakeholders and other HIV services providers who can provide information as well as support the goals of the Indiana HIV Jurisdictional Plan;

5. Determine Capacity Building Assistance and sources to support the planning process; and
6. Identify resources to assist in supporting the CPG planning process.

Evaluation Committee

Evaluation Committee shall consist of CPG members, one (1) HD technical advisor, and one (1) committee chair.

1. Address the four monitoring questions in the CDC HIV Guidance *(see Bylaws; article VI; section 2);*
    a. ***Question 1: Stakeholder Identification***
    To what extent did HIV service providers and other stakeholders who can best inform the coordination and collaboration of HIV prevention, care, and treatment services participate in the planning process?
    b. ***Question 2: Results-oriented Engagement Process***
    To what extent did the engagement process achieve a more coordinated, collaborative, and seamless approach to accessing HIV services for the highest-risk populations?
    c. ***Question 3: Jurisdictional HIV Prevention Plan Development, Implementation, and Monitoring***
    To what extent was input from HPG members, other stakeholders, and providers used to inform and monitor the development (or update) and implementation of the Jurisdictional HIV Prevention Plan?
    b. ***Question 4: Epidemiology Profile and Other Data Sources Review:***
    To what extent were surveillance and service data/indicators utilized to inform and monitor the development (or update) and the implementation of the Jurisdictional HIV Prevention Plan?
2. Develop monitoring/evaluation tools, surveys, and questionnaires to assess effectiveness of CPG related activities and operations, presentations from outside members, and committee work; and
3. Monitor and update (as needed) the Jurisdictional HIV Prevention Plan.

Membership/Stakeholder Identification Committee

Membership committee shall consist of CPG members, One (1) HD technical advisor, and one (1) committee chair.

1. Identify the needs for membership representation for the ten (10) regions in Indiana HIV Prevention Regional Map;
2. Define the membership application criteria for selection CPG members as well as maintaining parity, inclusion, and representation (PIR);
3. Assess, develop, and implement a recruiting process to fill CPG membership seats;
4. Assist in the orientation process of new members; and
5. Revise the membership application form as needed.

Policies & Procedures

Policies and Procedures Committee consists of CPG members, one (1) HD technical advisor, and one (1) committee chair.

1. Document Charter and Bylaws and/or policies and procedures of CPG when new structures or functions occur;
2. Review existing bylaws and/or policies and procedures and update them to reflect current structures and functions of CPG as they change;
    a. Committee members shall conduct a review of the bylaws and/or policies and procedures every 2-5 years and a full review every 5 years for restructure.
3. Ensure retention of current bylaws and policies and procedures in both hard copies and electronic formats.

Sexually Transmitted Disease (STD) Ad Hoc Committee

A. *Sexually Transmitted Disease Committee* shall consist of CPG members, one (1) HD technical advisor, and one (1) committee chair.

1. Provide periodic updates to full CPG body in regards to activities of the STD program as well as disease incidence and prevalence; and
2. Provide knowledgeable information on specific STDs, prevention efforts, care needs defined by highest-risk populations, and best practices.

APPENDIX E

Community Planning Group 2015 Committee Members List

Executive Committee
Latorya Greene, Community Co-Chair
Satin Francis, ISDH Co-Chair
Rochelle Feldheiser-Keyes
Darin Foltz, CPG Liaison
Christopher Simons
Ryan Nix
Timothy Chadwick

Advocacy/ Social Media Committee
Latorya Greene, Committee Chair
Satin Francis
Timothy Chadwick
Christopher Simons
Phaedra Greer
Darin Foltz

Evaluations Committee
Ryan Nix, Committee Chair
Aquanette Hudson
Breann Harris

Membership Committee
Rochelle Feldheiser Keyes, Committee Chair
Latorya Greene
Meredith Short
Brittany Gross
Darin Foltz

Engagement Committee
Christopher Simons, Committee Chair
Valorie Harvell
Timothy Chadwick
Satin Francis
Breann Harris
Brenda Mason
Darin Foltz

Policy & Procedures Committee
Latorya Greene, Committee Chair
Christopher Simons
Meredith Short
Ryan Nix
Darin Foltz

STD Committee
Rochelle Feldheiser-Keyes, Committee Chair
Aquanette Hudson
Darin Foltz